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Ticket: 0032018516 EX388348

LAB CODE

5046

Z A Quest Diagnostics Company

INSURANCE COMPANY INFORMATION

INSURANCE COMPANY FULL NAME

PRINCIPAL FINANCIAL DES MOINES IA

HOME OFFICE CITY

STATE

G VARNIAN PITTS FIELD MO

REFERENCE / POLICY / MEMBER / CONTRACT NUMBER

AGENT LAST NAME

AGENT FIRST NAME

FISCHMAN

ARI

TELEMUS

AGENT CODE

AGENT PHONE NUMBER

STATE

ZIP CODE

AGENT EMAIL ADDRESS

PROPOSED INSURED INFORMATION

LAST NAME

FISHMAN

FIRST NAME

RYAN

M.I.

GENDER

J

Male

Female

DATE OF BIRTH

SOCIAL SECURITY NUMBER

STREET ADDRESS

EMAIL ADDRESS

TEST REQUEST

☐ A1C ☐ CBC ☐ CDT☐ Full Drug ☐ Hepatitis☐ Microalbumin ☐ PSA

Other

In the past 5 years have you had a moving violation, or has your driver's license been restricted, suspended or revoked?

☐ Yes ☒ No

URINE TEMPERATURE

CURRENT MENSES

How many hours since you last ate/drank?

HEIGHT

WEIGHT

EXAMINING OFFICER

ExamOne 700

☐ ExamOne

Robert Skalski

BRANCH NUMBER

San Diego, CA

BRANCH ADDRESS

800-489-9528

Prior to allowing

I, the Proposed Insured, verify that the enclosed contents of this/these vial(s) is/are indeed my blood, urine and/or oral fluid specimen(s). I verify that my oral fluid specimen or urine specimen, if collected, was placed into a vial which was sealed with tamper-evident tape that I have signed. I acknowledge that I have read my information as captured on this ID form and verify that it is accurate.

NO ATTEMPT BY THE PROPOSED INSURED TO MODIFY OR AMEND THIS FORM WILL CHANGE ITS TERMS OR IN ANY WAY BE BINDING UPON THE INSURANCE COMPANY OR ANY OF ITS AGENTS OR CONTRACTORS

Signature of Proposed Insured / Legal Guardian

Month

Day

Year

Hour

Minute

I verify that the enclosed specimen(s) was/were properly collected. I further verify that this/these specimen(s) is/are in fact the specimen(s) collected from the Proposed Insured named on this ID form and that the proper barcode label has been placed by me on the specimen vial(s) for the Proposed Insured named on this ID form.

X

3

17

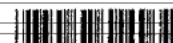
25

10

34

AM

PM



5046

BL 001789

Z



Principal[®] Principal Life Insurance Company
Principal National Life Insurance Company
Members of Principal Financial Group[®]

P.O. Box 10431
Des Moines, IA 50306-0431

**Medical
Questionnaire**

Only one company is the issuer and responsible for obligations of any given policy and is hereinafter referred to as "the Company".

Print full name of Proposed Insured

RYAN J FISHMAN

Date of Birth (Month/Day/Year)

6.24.88

4. In the last five years:

- a. have you had any medical tests (excluding tests for HIV (AIDS Virus), hospitalization, illness or injury not provided in response to a previous question? ☐ ☒
- b. have you consulted a doctor, ~~chiropractor~~, psychiatrist, psychologist, counselor, therapist or other healthcare provider not provided in response to a previous question? ☒ ☐

DETAILS TO QUESTIONS 1-8

For "yes" answers to questions 1-6 include dates, details, diagnosis, types and results of treatment, healthcare provider's full name and address. (if additional space needed, attach a separate page that is completed, witnessed, signed, and dated)

Quest. #	
1A	Zestiv Chiropractic Ryan 1-2 x month @ LEDINE CLINIC NORTHWESTERN DR, S66 FARMINGTON HILLS, MI

Medical Questionnaire, continued

☐ None

Phone Number

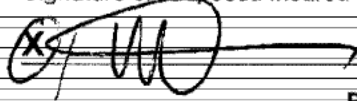
Zip

I have read the statements and answers recorded above; they are to the best of my knowledge and belief true, complete and correctly recorded. I agree that they will become part of my application and any policy issued on it.

Signature of Proposed Insured

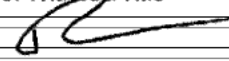
Date

Signature of Witness/Title



3-17-21

X



PHYSICAL MEASUREMENTS RECORDED BY EXAMINER

Name of agent soliciting application:

ARI FISERMAN (FISCHMAN)

Examination made at: ☐ Examiner's Office ☒ Applicant's Home ☐ Other

Examiner (print name)

B. Skalski

ExamOne 700

'ara Med.

Exam Company Name

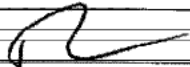
Robert Skalski

Exam Company Address

San Diego, CA

800-489-9528

Signature of Examiner X



Send exam to Home Office only.

ICC17 AA 672 N-1

(03/17)

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